TESTIMONY TO THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

on

HOME HEALTH FRAUD AND ABUSE IN THE MEDICARE PROGRAM

Presented by Mary L. Ellis, Vice President for Medicare

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Des Moines, Iowa

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Mr. Chairman and Members of the Committee:

I am Mary Ellis, Vice President for Medicare at Wellmark, Inc., headquartered in Des Moines, Iowa. Wellmark also does business as Blue Cross and Blue Shield of Iowa and South Dakota. My responsibilities include administration of the Medicare operations under contract to the Health Care Financing Administration (HCFA). We administer a Part B contract in Iowa, and a Part A contract for Iowa and South Dakota. In addition, we are the primary Regional Home Health Intermediary (RHHI) for the 10 states in HCFA Regions VII and VIII, and, as of August 4, 1997, we will add the five states plus the District of Columbia in HCFA Region III. We are also the alternate home health and hospice fiscal intermediary for the remainder of the United States and, as a result, have an administrative presence in all states.

The Home Health Fiscal Intermediary Structure

There are currently eight RHHIs in the United States, although two of them will exit this business over the next few weeks. The remaining six RHHIs are headquartered in South Carolina, Wisconsin, California, Maine, Illinois, and Iowa. In FY96, there were nearly 270 million home health visits nationally and $16.9 billion paid to home health providers.

Because Wellmark is the alternate RHHI for the US, we are in a unique position of being the only RHHI that deals with home health agencies throughout the country. If a home health provider requests a change in fiscal intermediary and receives approval from HCFA, the new fiscal intermediary, in most cases, is Wellmark. Although many very large home health companies have transferred to Wellmark for appropriate reasons, such as consolidation of multistate business under one fiscal intermediary, there are many others who have requested a change in fiscal intermediaries because a large percentage of their claims are being denied or repayments requested. These providers hope that they may be treated differently under a new fiscal intermediary. As a result, we provide oversight for a large number of potentially fraudulent agencies.

RHHI Responsibilities

Under the home health benefit, Medicare pays for skilled health care related to the treatment of an

illness or injury. To receive home health care, a beneficiary must be under the care of a physician who has determined that medical care in the home is appropriate and has prepared a plan of care. Furthermore, the beneficiary must be confined to the home and must be in a need of intermittent skilled nursing care, physical therapy, or speech pathology services. The care must be provided by a Medicare-certified home health agency. Home health aide services also may be provided to the eligible beneficiary to assist with personal care and required services of daily living. Medical social services and occupational therapy, as well as associated medical supplies also may be covered.

The responsibilities of the RHHIs include processing and paying home health and hospice claims, responding to inquiries from providers and beneficiaries, beneficiary outreach, provider education, reviewing claims for medical necessity, developing and implementing policies for prepayment review or denial of claims, identifying and investigating agencies with care practices and patterns outside of the standard practice norms, setting payment rates and monitoring reimbursements, settling cost reports and investigating questionable expenditures and billing practices, and developing and referring potentially fraudulent cases for further investigation and prosecution.

Growth in Expenditures and Utilization

Expenditures in home health services are one of the fastest growing components of Medicare. There are many reasons for this.

The Medicare population is growing in number. According to a recent report by the US Census, the over 65 population doubled in the 25 years prior to 1995 and the over 85 population increased by 274% in that time period.

The length of stay in hospitals has declined dramatically over the last decade. Many older people utilize home health services upon discharge. The number of home health providers has more than doubled over the past ten years to approximately 10,000 home health agencies, with 100 newly certified agencies now being added each month. Of the 38 million Medicare beneficiaries, approximately 9% now utilize the home health benefit.

Although these facts sound like a reasonable supply and demand situation, there is much more to the story.

Between 1988 and 1995, there was a 167 per cent increase in home health visits and a 38% annual increase in home health expenditures. Proprietary home health agencies comprise about half of all Medicare certified agencies and provide, on the average, more visits and have higher costs than the nonprofit agencies.

The average number of home health visits nationwide in 1996 was 70 visits per year per beneficiary served. There is a wide variation among states ranging from a low of 33 visits per beneficiary per year in the state of Washington to a high of 152 visits per beneficiary per year in Louisiana. The expenditures per visit also vary across the United States with a range in cost per beneficiary per state from $2,325 in Iowa to $8,579 in Louisiana and a nationwide average of $4,426.

I might add that the quality of care does not appear to be compromised by the lower home health expenditures in Iowa. For several years Iowa has led the nation with the highest proportion of people over the age of 85 and last year a major publishing company named Iowa the country's healthiest state. In fact, the top five states having the highest proportion of population over the age of 65 (North Dakota, South Dakota, Nebraska, Kansas, and Iowa), all are well below the national average in number of home

health visits and related costs per beneficiary. High costs and excessive numbers of home health visits do not appear to correlate with a long and healthy life.

Examples of Home Health Fraud and Abuse

Home health is an area of expenditure and growth that has had few constraints and offers few incentives for cost-conscious behavior. The norms of professional practice in home care are less well established than for more traditional health care. Work still needs to be done to establish standards for cost and utilization.

We are seeing a high volume of claims submitted by home health agencies that are for care that is not medically necessary, or was not provided at all, or for services that were never ordered by a physician, or where physicians orders were forged. Other claims are for beneficiaries who are not homebound and, therefore, are not eligible for this service. At times, we find that the care provided was not of high quality or not appropriate for the beneficiaries' needs.

Our financial auditors are finding significant amounts of unallowable expenses submitted in many providers' end-of-year cost reports. Examples are purchase of items for personal use, entertainment and gifts, personal loans, purchase of personal real estate, costs for operating non-related businesses, "phantom" employees, exorbitant salaries for the owner, family members on the payroll who may have other full-time jobs, and management employees who also collect social security disability checks. More serious situations have been found recently involving organized crime and the laundering of illegal drug money.

Identification of fraud and abuse

RHHIs receive fraud referrals from a variety of sources. Many complaints originate from Medicare beneficiaries and their families by phone or letter, or they are routed first through another agency such as a Congressional office or Social Security Administration. However, most of the beneficiary inquiries typically result in findings of billing errors, not fraud. It is also necessary to identify a pattern of questionable practices or aberrance before an investigation is initiated; it would be highly unusual for a case to be developed from one beneficiary complaint.

Other sources of fraud referrals include:

Employees of health care providers

Recently, RHHIs are seeing more cases that originate from a "Qui Tam"situation, brought forth by an insider or "whistle-blower" which entitles them to share a percentage of any civil recovery that the federal government collects from a fraudulent provider. Employees or ex-employees are often excellent leads for identifying Medicare fraud and developing a successful case against the guilty party.

Other agencies such as state survey and certification agencies, Medicaid, or law enforcement

Local health care fraud task forces composed of law enforcement agencies and other health care insurers

RHHI departments such as Medical Review and Provider Cost Report Auditing

Large scale identification of home health fraud or abuse is usually identified by the RHHI through provider audit and reimbursement methodology or through the medical review of claims. When patterns

of fraud and abuse emerge from either or both of these sources, the case is turned over to the RHHI's Anti-fraud Unit for further investigation and/or development for referral to external investigative or prosecuting agencies.

Activities of these RHHI departments are described below:

1. RHHI Medical Review activities

There are many edits programmed into the electronic claims processing system that cause claims to be suspended or denied prior to payment for lack of information, duplication, or other reasons. Data is collected and analyzed from this system in search of trends and patterns of inappropriate Medicare billings by specific providers and for specific topics.

Results of this analysis combined with review of referrals from outside sources are the basis for ongoing prevention efforts to reduce inappropriate payments.

Denial of claims and education of the provider who has a history of inappropriate billing practices next occurs. If no positive improvement is noted, then a comprehensive medical review is performed. This comprehensive review includes beneficiary interviews to validate the provider's billings.

If the comprehensive review and intense education of the agency staff still does not result in improvement of billing practices, the provider is referred to the RHHI Anti-Fraud Unit.

Unfortunately, the process of reviewing home health claims is limited by the lack of detailed information available on the home health bills. In addition, RHHI financial resources only allow for approximately 3% of home health claims to undergo a regular prepay medical review plus we were only able to conduct 50 onsite medical reviews in FY96. These 50 onsite reviews only enabled us to investigate the providers with the most obviously aberrant practice patterns.

2. RHHI Provider Audit and Reimbursement activities

Home health agencies are paid at cost for the services they provide to Medicare beneficiaries. When a home health agency submits a claim for payment, they are paid for each claim based on an established interim rate (usually an amount per visit). This interim rate is based on prior audit history and an estimate of the correct year-end total payment to the agency. At the end of each year, home health providers are required to submit a report of their costs related to services to Medicare beneficiaries.

Although all Medicare cost reports are audited, onsite audits are conducted for only a small number of these cost reports, depending on available funding from HCFA. Unfortunately, because of the large number of potentially corrupt agencies for which we bear responsibility, the low level of funds available in recent years has allowed us to audit only the "worst of the worst" agencies. We often find that providers report many costs that are not reimbursable by the Medicare program or they have not allocated the proper share of their total costs to Medicare. Audit adjustments are then proposed in order to remove any improper amounts included in the Medicare cost report. Adjustments are negotiated with the provider, a final settlement amount is determined, and an amount due and a repayment schedule to Medicare is established or, on occasion, an additional payment is made to the provider.

In FY96, our provider audit staff returned $26 to the Medicare program for every $1 of audit administrative expenditure. This amounted to $50,000,000 from annual home health audits. In addition, an audit of a large home health chain (who had collected $500 million a year from Medicare) recovered

$235,000,000 over four cost report periods. The owner of this chain was convicted and is now serving a jail sentence.

Although the provider audit department regularly refers fraud and abuse situations to our Anti-Fraud Unit for further investigation, these situations often are not resolved externally as criminal cases. The providers are frequently allowed to continue operating and the unresolved issues of fraud or abuse still exist. If the cases are accepted by external investigative agencies, it also takes a very long time to bring them to resolution. In the meantime, we are still responsible for recovering the multimillions of dollars due to Medicare from the inaccurate cost reports. In these situations, because there is no penalty for the provider, the agency can continue to abuse the Medicare system and it requires substantial audit resources to monitor and ensure a proper payment. Sometimes the debt owed to Medicare is very large, the provider files bankruptcy, and there is little money remaining for Medicare to recover. The current environment provides many options of administrative relief for the provider, but few options for the Medicare contractor to recover the funds.

3. RHHI Anti-Fraud Unit activities

The RHHI's medical review and provider audit departments described above refer potential fraud cases to the RHHI Anti-Fraud Unit.

Each RHHI has an anti-fraud unit whose duties include receiving and screening referrals or complaints concerning alleged Medicare fraud and abuse; investigating fraud referrals;

referring suspected fraud cases to federal law enforcement agencies and supporting their investigations; providing education regarding Medicare fraud to beneficiaries, RHHI employees, health care providers, and law enforcement agents; and helping maintain a nation-wide database of fraud investigation.

The first step in developing a fraud case is to screen each fraud referral to determine whether the issue involves a Medicare violation. Many referrals can be resolved at this stage as a misunderstanding, billing or processing error, or it may be forwarded to an external entity. For example, a complaint concerning the quality of medical care would be forwarded to the state's Board of Medical Examiners, or to the state's department for facility surveys and certifications.

A review is made of the provider's history with the RHHI to see if the current referral is a continuation of improper activity that has already been addressed with the provider, if the provider's billing data indicates an aberrant trend as compared to their peers, if it is an isolated incident, and to assess the amount of Medicare's financial exposure.

A determination is made whether the case should be referred to law enforcement for possible criminal and/or civil remedies. In some cases immediate referral is made to law enforcement, such as complaints made by a provider's employee, or allegations that kickbacks are being paid. RHHIs are required to first consult with the Department of Health and Human Services' Office of Inspector General (OIG). If the OIG declines the case, it may be referred to another law enforcement agency such as the FBI or US Postal Inspections. If the fraud case is accepted by a law enforcement agency, then the RHHI supports law enforcement and prosecuting agencies by providing supporting documentation, claims data analysis, and expert assistance with issues such as Medicare guidelines and policy, medical necessity, and Medicare cost reports.

If a case is determined to not involve fraud and is declined by law enforcement, then the RHHI will attempt to collect any overpayment that was identified and provide formal notice to the health care

provider of the Medicare guideline and policy violations that occurred. The activities of these providers are then closely monitored for a period of time.

Funding Source for Anti-Fraud Activities

Medicare contractors have learned to become extremely efficient with limited funds. The total contractor administrative budgets have been reduced by 5 to 7% each year for the past several years while workloads increased. Electronic billing systems and other efficiencies have enabled basic claims processing operations to continue most activities, but monitoring of claims and provider activities have declined dramatically due to the lack of funds. For example, prepayment review of only 3% of beneficiary bills paid is not nearly adequate, nor is the reliance on review of paper claims submitted. The lack of onsite audits allows abuse to run rampant. Fraudulent providers are willing to take the fairly safe risk of not being subjected to intense scrutiny as they continue inappropriate practices.

The Health Insurance Portability and Accountability Act of 1996 will provide much needed funding initiatives to assist in anti fraud efforts. It will provide a permanent mandatory source of funding from the Medicare Trust Fund for Medicare contractor anti-fraud efforts for Medical Review, provider audit functions, and other anti-fraud activities. Unfortunately, the funding reductions for Medicare contractors in this and past years have greatly decreased anti-fraud and monitoring of provider activities. A huge backlog of problems has been allowed to mount.

National Projects and New Initiatives

Operation Restore Trust is a two year pilot program initiated in 1995 to focus on fraud and abuse in the five states where 1/3 of all beneficiaries reside. Agencies with extraordinarily high utilization, inappropriate billing practices, or numerous allegations of questionable activities were targeted for intensive scrutiny. Increased sharing of information between state surveyors and RHHIs, as well as among all investigative agencies, was encouraged. This project has been very successful in uncovering substantial fraudulent activities and recovery of Medicare funds, and is now being expanded to an additional twelve states.

HCFA is considering several new activities to strengthen the Medicare program administratively. Among these are an outcome assessment process for evaluation of results of home health care to beneficiaries; new conditions of participation that hold the agency accountable for better coordination of care, establish limits on subcontracting for caregivers, establish criteria for the agency management, require more information to patients regarding expectations about their care, and encourage more physician involvement in patient care; encouraging more involvement between RHHIs and state surveyors for certification; addressing the need for more consistency and strength in states' certification; and a new prospective payment system.

Remaining Problems

Problems that have an urgent need to be addressed are:

<u>Lack of resources</u>

Each year's regular reduction in administrative funding to Medicare contractors has severely limited our ability to combat fraud and abuse effectively and to carry out basic claims processing and related activities. As the workload increases, the operational resources decline. Many contractors are now expecting to exit the Medicare fee for service business because their private business parent is finding it

necessary to subsidize their fee for service operations. Obviously, that can not continue.

Although the more stable funding source provided by the Health Insurance Portability and Accountability Act of 1996 will greatly assist fraud and abuse efforts, adequate and stable funding levels are also essential to accomplish the tasks involved in basic administration of the Medicare program operations in order to maintain quality service to beneficiaries and providers.

Lack of administrative tools to prevent payment

While the court system attempts to deal with its backlogs of cases to prosecute, we are concerned that many of these cases will be disposed of by settlements at far lower amounts than the actual provider liability. For example, the RHHI may have determined that a clever, corrupt provider has been paid $10 million dollars incorrectly, but the case may be settled for $5 million because that is all the money the provider has left. Then it has been very worthwhile for that provider to defraud the government and he has gained much from the experience. He did not go to jail and is then able to plan his next criminal venture.

Please note that this is not a criticism of the investigative or prosecuting arms of government, but only a statement of situational reality due to the high volume of cases and their complexity.

Explanation of Medicare Benefits (EOMB)

The Health Insurance Portability and Accountability Act of 1996 included direction to Medicare contractors to send an Explanation of Medicare Benefits (EOMB) for all services rendered as part of a Medicare benefit. If the primary purpose of this activity is for the beneficiary to maintain a medical record of their Medicare services and to enhance customer service, then this may be an appropriate expenditure of funds. However, if this activity is meant to be a first line strategy to assist Medicare contractors in identifying fraud and abuse, then it is a very expensive strategy with a very low return.

EOMBs have primarily been sent only when the beneficiary had a liability for payment of a portion of the services. Due to the high cost of administration, EOMBs have not traditionally been sent for services paid solely by the Medicare program. In FY97, RHHIs were instructed to mail Notices of Utilization (NOUs) to beneficiaries receiving home health services. The costs of printing, mailing, and responding to inquiries to the NOUs has cost Wellmark approximately $1.2 million with actual recovery of only $1100 attributed to this source. The other RHHIs report similar experiences.

After receiving the NOUs, many beneficiaries call or write to report a billing error or to tell us that they appreciate home health service and fear that we will stop paying for it. Very few calls are actually fraud referrals. The thousands of additional calls and correspondence severely tax limited administrative resources and have required hundreds of hours of overtime pay and reduction of staff in other departments this year. There have been no additional funds made available for this activity and, in fact, it has occurred within a reduced administrative budget. Again, it is not unlikely that the private insurance company parent is actually subsidizing these government efforts for some of the Medicare contractors.

In addition, the undeliverable mail returned for the NOUs is approximately 10% of all NOUs sent. Our offices alone have now collected at least 50,000 returned envelopes in the past 6 months.

Pilot projects are in process in several locations to test sending EOMBs for all other types of services paid by Medicare. When this activity occurs nationwide for over 900 million claims over the next years,

the expenditures for mailing and follow-up will consume an enormous amount of money. It will be unfortunate if these funds compete with expenditures for preventing and recovering the multimillions of dollars now leaving the Medicare program due to fraud and abuse by clever criminals, or with expenditures necessary for accurate processing of Medicare claims.

If the EOMBs must continue to be sent, then there also should be an aggressive educational process to encourage beneficiaries and their families to take a more active role in their health care, to ask questions of their providers about that care, and to keep a log of home health visits.

Inability to bring fraud cases to resolution

The legal system is bogged down with too many cases of all types to expeditiously handle the backlog of home health cases. There is also a lack of resources or inability to deal with home health fraud cases, of which many are complicated.

We estimate is that it takes four years from first identification of fraud through the RHHI until resolution of the case. Continuing to monitor these potentially fraudulent agencies while they await further investigation or prosecution stretches limited RHHI resources. The problem also is perpetuated as the providers continue to operate and we continue to pay them. There are no sound mechanisms for stopping payment prior to prosecution or other resolution.

Againk this is not a criticism of our investigative partners, but only an acknowledgement of an overloaded system.

Need for increased knowledge about the Medicare program

The recent emphasis on home health fraud has caused investigative agencies to seek more knowledge about the Medicare program. Our anti-fraud staff are now in great demand as trainers and presenters regarding Medicare policies and procedures at seminars for the FBI and U.S. Attorneys.

In addition, administrative law judges (of the Social Security Administration) overturn many RHHI decisions on appeal. We believe that this also occurs due to a need for better understanding of the complexities of the Medicare program and the health care system.

Manipulation of the system by corrupt providers

Some providers have learned to manipulate the complex system in their own best interest. In some cases, they have even persuaded elected officials to write us letters requesting approval for questionable practices (e.g. allowing high salaries for agency management, longer repayment schedules, or other costly and aberrant practices).

Auditor site visits to certain locations has also become a great concern. There have been instances of firearms on the premises and other potentially dangerous situations.

Conclusion

It is important to note that most home health providers are honest and do not attempt to defraud or abuse the Medicare system. Only a small percent of home health agencies are currently found to exhibit fraudulent practices. But it is a system highly vulnerable to exploitation.

The Medicare system and its related parts are enormously complex. It is, however, a critical and essential program to our citizens and it is necessary to attempt to understand and maintain it. Your continued attention to improving its operation is appreciated.

Thank you for the opportunity to testify today.